President’s Message

Barbara Kelly

The 2010 ANA House of Delegates, held June 16-19 in Washington DC, was an exciting, informative and inspirational event. Nurses across the nation gathered together to help shape the future of nursing and health care in this country. We discussed, debated and refined resolutions that were ultimately passed by the House. A few of the resolutions required more discussion and compromise, others were easily agreed upon. Later in the week, over 800 delegates from all 50 states, including one delegate from Indiana, gathered in Chicago to deliberate and take action on the resolutions that we passed at the ANA House of Delegates. A very special event during the HOD involved a panel discussion from ANA past presidents. The President stated he felt that each of the panel members had brought value to the discussion. He applauded the work of each of our members, Mary Cisco and Jenna Sanders, to serve on the Congress on Nursing Practice and Economics. We were inspired by the surprise visit from President Obama who commended nurses for our long standing dedication and vision for access to health care. He applauded our work for safe patient care, health care and policy, professional excellence and reiterated his commitment to nursing education and the contributions we make. The President stated he will continue to promote our work in healthcare, especially in the primary care arena. There was no mistake...our voices are being heard.

A very special event during the HOD included a panel discussion from ANA past presidents. Each left a vital contribution to our profession. It was obvious from the discussion that these leaders have a shared vision for and profound commitment to the advancement of nursing. Each contribution built upon the work of the previous presidents, staff and membership. The resounding themes were: We can, we may not all agree on all parts of the Health Care Reform Bill, but one thing is for certain, ANA was at the table giving a voice to the patients and nurses we serve, voice to our nurses that our voices count. “We have made coming and going resolutions from previous ANA presidents included, “ We stand on the shoulders of others before us who advocated for those standards, ideals, dreams of all nurses”, “nation needs nurses during ordinary and extraordinary times”, “education is required for practice in any setting...we cannot practice what we do not know...education gives us a right to compete”, “the voice of Nursing is about patient safety, quality and performance “, and “we may fight behind closed doors, but we are one voice in public”. There was an abundance of wisdom from these leaders. It was an honor to listen to their stories. We could not have been more proud to be a nurse and a member of ISNA and the American Nurses Association.

As the House of Delegates closed I was tired, but proud and honored to work with nurses across the nation to give voice to all nurses and to the patients we serve. Our state and national organization are here to serve you. By being part of our professional organization we make a difference in health care and public policy, standards of nursing practice, nursing knowledge and research, quality outcomes, workplace advocacy, safe patient care, professional excellence, environmental responsibility. At the end of the week we were exhausted but pleased as to what we accomplished collectively. Thank you for the privilege of serving you at the ANA House of Delegates.

Inside This Issue

Welcome to New and Reinstated ISNA Members: 3
ISNA Membership Application: 3
CE Activities Approved: 4
Certification Corner: 4
Indiana Nurses Calendar: 5
The House of Nursing 2010: ANA Delegates’ Reports: 6-7
ISNA Board Summaries: 8
Independent Study: The Importance of Adult Immunization: 9-13

A New Way to Connect with ISNA

ISNA INDIVIDUAL DIRECT MEMBERS:
• May participate in ISNA activities
• Can vote for and serve on ISNA Board of Directors or Nominating Committee and as Secretary,
• Can be appointed to serve on ISNA committees
• Will have access to the Members Only section of the ISNA website.
• Will receive all member discounts on ISNA events.
• Cannot serve as ISNA President, Vice President, Treasurer, or delegate to ANA.
• Cannot run for national office nor serve on ANA committees
• Will not get ANCC certification or publication discounts
• Will not have access to ANA member only web pages.

ISNA/ANA MEMBERS:
• Can vote in ISNA elections
• Can serve as delegates to the ANA House of Delegates.
• Can be appointed/elected to serve to ISNA, ANA, ANCC or Academy positions
• Have access to Members Only section of the ISNA and ANA websites.
• Receive all publications from ISNA and ANA including the ISNA Bulletin, The Indiana Nurse, American Nurse and American Nursing
• Receive member discounts on ANA publications and ANCC certification

Join online at: www.indianaNurses.org
and click on Join/Renew, then ISNA/ANA combined

Primo Banquet Center South, Indianapolis
The ISNA Annual Meeting of the Members
Primo Banquet Center South, Indianapolis
Keynote: ANA and You
Karen Daley, PhD, RN
President, American Nurses Association
Continuing Nursing Education
ANA’s Revised (2010) Scope and Standards of Nursing Practice
Ann O’Sullivan, RN, MSN, NE-BC, CNE
Assistant Dean, Associate Professor, Blessing-Rieman College of Nursing, Quincy, IL
Ann chaired the most recent ANA workgroup who did the revision of the 2010 Nursing Scope and Standards of Practice document.

ISNA Policy Setting
Resolutions
Public Policy Platform
Bylaw Amendments

Complete meeting information will be mailed to ISNA members. Information, including registration details is also available online at www.indianaNurses.org

Quarterly circulation approximately 115,000 to all RNs and LPNs in Indiana.
ISNA MISSION STATEMENT

ISNA works through its members to promote and influence quality nursing and health care.

ISNA accomplishes its mission through advocacy, education, information, and leadership.

ISNA is a multi-purpose professional association serving registered nurses since 1903.

ISNA is a constituent member of the American Nurses Association.

BULLETIN COPY DEADLINE DATES

All ISNA members are encouraged to submit material for publication that is of interest to nurses. The material will be reviewed and may be edited for publication. To submit an article mail to ISNA Bulletin, 2915 North High School Road, Indianapolis, IN 46224-2969 or E-mail to klein@indiananurses.org.

The ISNA Bulletin is published quarterly. Copy deadline is December 15 for publication in the February/March/April ISNA Bulletin; March 15 for May/June/July publication; June 15 for August/September/October, and September 15 for November/December/January.

If you wish additional information or have questions, please contact ISNA headquarters.

For advertising rates and information, please contact Arthur L. Davis Publishing Agency, Inc., 517 Washington Street, PO Box 216, Cedar Falls, Iowa 50613, (800) 626-4081, sales@aldpub.com. ISNA and the Arthur L. Davis Publishing Agency, Inc. reserve the right to reject any advertisement. Responsibility for errors in advertising is limited to corrections in the next issue or refund of price of advertisement.

Acceptance of advertising does not imply endorsement or approval by the Indiana State Nurses Association of products advertised, the advertisers, or the claims made. Rejection of an advertisement does not imply a product offered for advertising is without merit, or that the manufacturer lacks integrity, or that this association disapproves of the product or its use. ISNA and the Arthur L. Davis Publishing Agency, Inc. shall not be held liable for any consequences resulting from purchase or use of an advertiser’s product. Articles appearing in this publication express the opinions of the authors; they do not necessarily reflect views of the staff, board, or membership of ISNA or those of the national or local associations.
### Welcome to New and Reinstated ISNA Members

<table>
<thead>
<tr>
<th>Name</th>
<th>City, State, Zip+4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kathleen Auberry</td>
<td>Trafalgar, IN</td>
</tr>
<tr>
<td>Susan Bell</td>
<td>Columbus, IN</td>
</tr>
<tr>
<td>Kathryn Bennett</td>
<td>Jaffersonville, IN</td>
</tr>
<tr>
<td>Suzanne Bernat</td>
<td>Hobart, IN</td>
</tr>
<tr>
<td>Kimberly Berry</td>
<td>Indianapolis, IN</td>
</tr>
<tr>
<td>Stephanie Calabrese</td>
<td>Salem, IN</td>
</tr>
<tr>
<td>Dorothy Callin</td>
<td>Rosedale, IN</td>
</tr>
<tr>
<td>Alice Cheesman</td>
<td>Hutsenville, IL</td>
</tr>
<tr>
<td>Holly Cook</td>
<td>Indianapolis, IN</td>
</tr>
<tr>
<td>Alicia Cox</td>
<td>Cannelburg, IN</td>
</tr>
<tr>
<td>James Crowley</td>
<td>Wadsworth, OH</td>
</tr>
<tr>
<td>Vicki Doty</td>
<td>Newburgh, IN</td>
</tr>
<tr>
<td>Ruth Dwyer</td>
<td>Bloomington, IN</td>
</tr>
<tr>
<td>Diane Feder</td>
<td>Lebanon, IN</td>
</tr>
<tr>
<td>Caroline Fernandez</td>
<td>Schererville, IN</td>
</tr>
<tr>
<td>Kathy Fox</td>
<td>Beech Grove, IN</td>
</tr>
<tr>
<td>Merrill Frey</td>
<td>Crown Point, IN</td>
</tr>
<tr>
<td>Ann Gang</td>
<td>Indianapolis, IN</td>
</tr>
<tr>
<td>Geoffrey Gephart</td>
<td>Fort Wayne, IN</td>
</tr>
<tr>
<td>Sarah Gricch</td>
<td>Valparaiso, IN</td>
</tr>
<tr>
<td>Holly Gullett</td>
<td>Carmel, IN</td>
</tr>
<tr>
<td>Susan Gunn</td>
<td>Brownsburg, IN</td>
</tr>
<tr>
<td>Kathleen Haughan</td>
<td>Avon, IN</td>
</tr>
<tr>
<td>Sarah Hayes</td>
<td>Indianapolis, IN</td>
</tr>
<tr>
<td>Barbara Hickman</td>
<td>Michonneville, IN</td>
</tr>
<tr>
<td>Kimberley Himelick</td>
<td>Marion, IN</td>
</tr>
<tr>
<td>Janet Jesaulitis</td>
<td>Avon, IN</td>
</tr>
<tr>
<td>Pamela Karagory</td>
<td>Lafayette, IN</td>
</tr>
<tr>
<td>Patricia Kreischer</td>
<td>North Judson, IN</td>
</tr>
<tr>
<td>Karen Lahr Carmel</td>
<td>Carmel, IN</td>
</tr>
<tr>
<td>Dahnethelena Lenoir</td>
<td>Mikelville, IN</td>
</tr>
<tr>
<td>Kitty Ludlow</td>
<td>Bloomington, IN</td>
</tr>
<tr>
<td>Katherine McKinney</td>
<td>Evansville, IN</td>
</tr>
<tr>
<td>Juliana Mwone</td>
<td>South Bend, IN</td>
</tr>
<tr>
<td>Jan Neylon</td>
<td>Greenwood, IN</td>
</tr>
<tr>
<td>Julie Ote</td>
<td>Indianapolis, IN</td>
</tr>
<tr>
<td>Tracie Pettit</td>
<td>Indianapolis, IN</td>
</tr>
<tr>
<td>Nancy Patock</td>
<td>Anderson, IN</td>
</tr>
<tr>
<td>Janet Plahn</td>
<td>Vincennes, IN</td>
</tr>
<tr>
<td>Janice Price</td>
<td>Indianapolis, IN</td>
</tr>
<tr>
<td>Linda Ramey</td>
<td>Hartford City, IN</td>
</tr>
<tr>
<td>Lisa Rhodes</td>
<td>Georgetown, IN</td>
</tr>
<tr>
<td>Peggy Rose</td>
<td>Michigan City, IN</td>
</tr>
<tr>
<td>Melanie Russell</td>
<td>Arcadia, IN</td>
</tr>
<tr>
<td>Sherri Russel</td>
<td>Indianapolis, IN</td>
</tr>
<tr>
<td>Kathleen Rynard</td>
<td>Indianapolis, IN</td>
</tr>
<tr>
<td>Debra Sipes-Fears</td>
<td>Plainfield, IN</td>
</tr>
<tr>
<td>Melissa Somerville</td>
<td>Fort Wayne, IN</td>
</tr>
<tr>
<td>Erik Southard</td>
<td>Terre Haute, IN</td>
</tr>
<tr>
<td>Kathleen Strasser</td>
<td>Moores Hill, IN</td>
</tr>
<tr>
<td>Ruth Styron</td>
<td>Columbus, IN</td>
</tr>
<tr>
<td>Elizabeth Swank</td>
<td>Vincennes, IN</td>
</tr>
<tr>
<td>Karen Vallageon</td>
<td>Porter, IN</td>
</tr>
<tr>
<td>Mila Walker</td>
<td>Noblesville, IN</td>
</tr>
<tr>
<td>Loretta Wiggins</td>
<td>Granger, IN</td>
</tr>
<tr>
<td>Ashley Wilson</td>
<td>Indianapolis, IN</td>
</tr>
<tr>
<td>Hannah Yoder</td>
<td>Goodland, IN</td>
</tr>
<tr>
<td>Judith Young</td>
<td>Martinsville, IN</td>
</tr>
<tr>
<td>Sheila Zimmerman</td>
<td>Lebanon, IN</td>
</tr>
</tbody>
</table>

---

#### APPLICATION FOR RN MEMBERSHIP in ANA and ISNA

**PLEASE PRINT OR TYPE**

<table>
<thead>
<tr>
<th>Last Name, First Name, Middle Initial</th>
<th>Name of Basic School of Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____________________________________</td>
<td>_______________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street or P.O. Box</th>
<th>Home phone number &amp; area code</th>
</tr>
</thead>
<tbody>
<tr>
<td>___________________</td>
<td>______________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>County of Residence</th>
<th>Work phone number &amp; area code</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____________________</td>
<td>______________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City, State, Zip+4</th>
<th>Preferred email address</th>
</tr>
</thead>
<tbody>
<tr>
<td>___________________</td>
<td>_________________________</td>
</tr>
</tbody>
</table>

---

1. **SELECT PAY CATEGORY**

   - **Full Dues – 100%**
     - Employed full or part time.
     - Annual: $229.

   - **Reduced Dues – 50%**
     - Not employed, full-time student, or 62 years or older.
     - Annual: $135.50.

   - **Special Dues – 25%**
     - 62 years or older and not employed or permanently disabled.
     - Annual: $87.25.

2. **SELECT PAYMENT TYPE**

   - FULL PAY – CHECK
   - FULL PAY – BANKCARD

3. **SEND COMPLETED FORM AND PAYMENT TO**

   **PAYMENT TO**

   American Nurses Association
   P.O. Box 504345
   St. Louis, MO 63150-4345

---

#### ELECTRONIC DUES PAYMENT PLAN, MONTHLY

The Electronic Dues Payment Plan (EDPP) provides for convenient monthly payment of dues through automatic monthly electronic transfer from your checking account.

To authorize this method of monthly payment of dues, please read, sign the authorization below, and enclose a check for the first month (full $22.92, reduced $13.71), please read, sign the authorization below, and enclose a check for the first month (full $22.92, reduced $13.71).

This authorizes ANA to withdraw 1/12 of my annual dues and the specified service fee of $0.50 each month from my checking account. It is to be withdrawn on/after the 15th day of each month. The checking account designated and maintained is as shown on the enclosed check.

The amount to be withdrawn is $0.50 each month. ANA is authorized to change the amount by giving me (the under-signed) thirty (30) days written notice.

To cancel the authorization, I will provide ANA written notification thirty (30) days prior to the deduction date.

Signature for Electronic Dues Payment Plan

---

#### 3. SEND COMPLETED FORM AND PAYMENT TO

**American Nurses Association**

P.O. Box 504345

St. Louis, MO 63150-4345
An unusual partnership has developed at one Indiana hospital. The hospital has always provided reimbursement for successful certification. Now, it has gone one step further.

The current economic climate has adversely affected nurses as well as other professionals. Many are currently the only breadwinner for their families and are struggling to make ends meet. In spite of this, they also want to enhance their own professional development through certification. They are able to attend certification review courses free of charge, but the cost of a certification exam continues to increase and the reimbursement only pays for about half of the total cost. They can charge the exam cost, but being out-of-pocket for up to $200 makes taking the exam prohibitive for many nurses.

The hospital Foundation Board is very focused on nursing professional development. When they heard that nurses who wanted certification couldn’t afford to take the test with the current reimbursement available, they went into action. They appropriated extra funding to enable these nurses to become certified at no additional cost to themselves.

Nurses who otherwise could not become certified, now have that opportunity. This partnership between hospital nurses and Foundation board members is working and the ultimate benefit is to the patients they serve. That’s a true success story!

I’d like to hear your certification stories. Please contact me at Sue.Johnson@parkview.com to share your experiences.
### Indiana Nurses Calendar

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Event/Location</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 9, 2010</td>
<td>ISNA CNE Information Conference Call All welcome. For more information and to obtain the conference call number, call ISNA</td>
<td>Indiana State Nurses Association, Phone: 317/299-4575 <a href="http://www.indiananurses.org">www.indiananurses.org</a> Email: <a href="mailto:ce@indiananurses.org">ce@indiananurses.org</a></td>
</tr>
<tr>
<td>August 12-22, 2010</td>
<td>International Nursing Study Tour of Italy Contact Judy D'Angelo, RN, MS, ANP email: <a href="mailto:jdalongo@frontiernet.net">jdalongo@frontiernet.net</a></td>
<td>Wilson Shepard Education Associates Phone 585/473-7804 <a href="http://www.wshep.com/destiny_seminar.html">http://www.wshep.com/destiny_seminar.html</a></td>
</tr>
<tr>
<td>August 13, 2010</td>
<td>ISNA Board Meeting 9:30 A.M., ISNA office, 2915 N High School Road, Indianapolis, IN 46224</td>
<td>Indiana State Nurses Association, Phone: 317/299-4575 <a href="http://www.indiananurses.org">www.indiananurses.org</a> Email: <a href="mailto:ce@indiananurses.org">ce@indiananurses.org</a></td>
</tr>
<tr>
<td>August 13, 2010</td>
<td>ISNA Organization of Nursing Executives Board Meeting/Hendricks Regional Health, 1100 Southfield Dr., 2nd Floor, Plainfield, IN 317/839-7200</td>
<td><a href="http://www.indiananurses.org">www.indiananurses.org</a> Email: <a href="mailto:ce@indiananurses.org">ce@indiananurses.org</a></td>
</tr>
<tr>
<td>Sept 24, 2010</td>
<td>Annual ISNA Meeting of the Members More info to come</td>
<td>Indiana State Nurses Association, Phone: 317/299-4575 <a href="http://www.indiananurses.org">www.indiananurses.org</a> Email: <a href="mailto:ce@indiananurses.org">ce@indiananurses.org</a></td>
</tr>
<tr>
<td>October 10, 2010</td>
<td>A Multidisciplinary Approach to Obesity – St. Vincent Hospital Ritz Charles, 12156 N. Meridian Street, Carmel, Indiana</td>
<td>bariatricst.vincent.org or call 1-866-338-CARE (2273)</td>
</tr>
<tr>
<td>October 19, 2010</td>
<td>Indiana Organization of Nursing Executives 1:00 P.M., Board Meeting/Brown County Inn, Brown County, IN</td>
<td>IONE, Phone 317/423-7731 <a href="http://www.indianaone.org/id3/html">http://www.indianaone.org/id3/html</a> Email: <a href="mailto:mbisesi@johnsonmemorial.org">mbisesi@johnsonmemorial.org</a></td>
</tr>
<tr>
<td>November 3-4, 2010</td>
<td>Indiana Association of School Nurses Annual Conference at Indianapolis Marriott East &quot;Under Construction: A Blueprint for Building Effective School Nursing Practice&quot;</td>
<td>IASN, Phone 765/362-7493</td>
</tr>
<tr>
<td>November 5, 2010</td>
<td>Indiana State Nurses Association Committee on Approval Meeting Semi Annual Meeting</td>
<td>Indiana State Nurses Association, Phone: 317/299-4575 <a href="http://www.indiananurses.org">www.indiananurses.org</a> Email: <a href="mailto:ce@indiananurses.org">ce@indiananurses.org</a></td>
</tr>
<tr>
<td>November 12, 2010</td>
<td>Indiana Organization of Nursing Executives 10:00 A.M., Board Meeting/Hendricks Regional Health, 1100 Southfield Dr., 2nd Floor, Plainfield, IN 317/839-7200</td>
<td>IONE, Phone 317/423-7731 <a href="http://www.indianaone.org/id3/html">http://www.indianaone.org/id3/html</a> Email: <a href="mailto:mbisesi@johnsonmemorial.org">mbisesi@johnsonmemorial.org</a></td>
</tr>
<tr>
<td>Open Enrollment</td>
<td>&quot;Being a Preceptor in a Healthcare Facility&quot;—Open Enrollment. This course will acquaint you with the role of preceptor, working with the faculty /instructor and students from a school of nursing. Self-paced format.</td>
<td>Indiana University School of Nursing, Phone: 317/274-7779 <a href="http://nursing.iupui.edu/continuing/">http://nursing.iupui.edu/continuing/</a> Email: <a href="mailto:censg@iupui.edu">censg@iupui.edu</a></td>
</tr>
<tr>
<td>Open Enrollment</td>
<td>&quot;Being a Preceptor in a School of Nursing&quot;—Open Enrollment. This course will acquaint you with the role of preceptor, working with the faculty /instructor and students from a school of nursing. Self-paced format.</td>
<td>Indiana University School of Nursing, Phone: 317/274-7779 <a href="http://nursing.iupui.edu/continuing/">http://nursing.iupui.edu/continuing/</a> Email: <a href="mailto:censg@iupui.edu">censg@iupui.edu</a></td>
</tr>
</tbody>
</table>
Esther Acree

We had quite a surprise in the change from Vice President Joe Biden to President Barack Obama being our special speaker at the HOD. A very nice surprise for us even though some had seen him before in political and professional settings. We all are very concerned about his health care in this country. He was and still is emphatic that nursing is the heart of the healthcare system and we will all be working together to make healthcare reform equitable and workable for all people in this age of skyrocketing costs. A continuing emphasis of ANA is to work proactively on patient safety issues for patient care. A copy of his speech with pictures and video, etc, is available at: http://www.whitehouse.gov/the-press-office/remarks-president-american-nurses-association

Another momentous event was the former ANA President’s presentations on how the Health Reform movement has come through ANA and is being our special speaker at the HOD. A very nice surprise for us even though some had seen him before in political and professional settings. We all are very concerned about his health care in this country. He was and still is emphatic that nursing is the heart of the healthcare system and we will all be working together to make healthcare reform equitable and workable for all people in this age of skyrocketing costs. A continuing emphasis of ANA is to work proactively on patient safety issues for patient care. A copy of his speech with pictures and video, etc, is available at: http://www.whitehouse.gov/the-press-office/remarks-president-american-nurses-association

The action report on Mentoring Programs for Novice Nurses was submitted by the Massachusetts Nurses Association. The resolution reaffirms ANA’s support of initiatives to facilitate the successful integration of novice nurses into the healthcare workplace and that the ANA should partner with CMA’s, IMDb, and other nursing organizations to develop mentoring programs. It also requests the ANA to support the findings of these projects. All who spoke were in support of the resolution and several examples of pilot projects were discussed.

Janet Blossom

The 2010 Biennial meeting of the ANA House of Delegates in Washington, D.C. was definitely a historical event. The elected delegates, attendees, and ANA staff did an incredible job. I enjoyed the opportunity to serve as a delegate.

The Bylaw changes went more swiftly than expected. The associate member category did not pass the HOD. The distillation of the pilots a membership superseded this and it was felt this category was not necessary at this time.

The most exciting part was the elections. ANA has a new President. Karen Daley. Karen, as you may remember, was a staff nurse who had a needlestick incident during her 2 years as a nurse. The HOD identified Karen as a powerful figure and an inspiration for ANA’s work. We are extremely proud of her and her vision for our future organization. It was easily seen that the many and varied as well as all nurses, especially novice nurses were running in the election.

The action report on Hostility, Abuse and Bullying in the workplace and Mentoring Programs for Novice Nurses. Both of these action reports were adopted. The action report on Hostility, Abuse and Bullying in the workplace was submitted by the Federal Nurses Association. The resolution seeks to reaffirm and support the existing principles of its policy, which states that all health care settings are expected to be free from abuse and harassment of nurses and the promotion of healthy work and professional environments for all nurses. The resolution also seeks to address the growing problem of workplace abuse, harassment, and bullying of nurses and the serious consequences, including severe physical and psychological injuries. Several delegate shared successful efforts in their states to make abuse against nurses a felony.

The action report on Mentoring Programs for Novice Nurses was submitted by the Massachusetts Nurses Association. The resolution reaffirms ANA’s support of initiatives to facilitate the successful integration of novice nurses into the healthcare workplace and that the ANA should partner with CMA’s, IMDb, and other nursing organizations to develop mentoring programs. It also requests the ANA to support the findings of these projects. All who spoke were in support of the resolution and several examples of pilot projects were discussed.

My next assignment was a proposed Bylaw amendment #5 Article V Sect. 6A with the intent to extend ANA officers terms in office to 4 years and provide staggering with that change to begin in 2014 with President and 1st Vice President. The arguments for the proposal included to provide more continuity. The change presents a transitional period with a downscalation of the ANA’s workload, because few nurses can afford to be away from work and family for that length of time. Being elected as ANA President is more than a full time job with extensive national and international traveling and is compensated. Imagine trying to plan to be away from your job for a week and have to prepare your delegation with 76.1% of Delegates voting against this change in the Bylaws.

Mary Cisco

It was a pleasure to attend the ANA House of Delegates (HOD) with the delegates from Indiana. This was a full time job with extensive national and international traveling and is compensated. I was able to attend HOD and have the opportunity to speak with the other delegates from Indiana and the organization itself. I was honored to be part of the Indiana delegation this year.

The House of Nursing 2010 continued on page 7

Joyce Darnell

This House of Delegates meeting was different from the start. There was an air of excitement and enthusiasm within our team and members from other states as we hammered out our issues (bylaws, resolutions) and built consensus as an organization. I encourage everyone to attend a HOD! I learned so much and formed many relationships. It is truly an opportunity you won’t want to miss! So, you have a little less than two years to prepare your travel, ask off from work and get current on the issues in order to make a difference when voting. Thanks again for this opportunity! See you at the next House of Delegates in 2012!

The House of Nursing 2010 continued on page 7
the evidence that says, “…this is best nursing practice.”

You may be asking why should or how can I participate? The why is simple. Professional nurses participate. If you are a member of ISNA you are participating in the broadest way possible as far as professional organizations go. Most ISNA members are also members of the ANA which represents the interests of 1 million RNs. If you are a member of ISNA you represent over 65,000 RNs in the state of Indiana. If your interest and ability allows you only to participate in this way only you are doing a great service to the profession. It gives the association the ability to support those who are able to participate in more specific ways. This could include committee work, special projects, or even board work.

As I found out recently, our voices are important. Not only to each other as professionals but also to the communities that we serve and care for. Our participation in this process is necessary and an important part of being a “professional nurse”.

being treated later at a more complicated point of the disease process resulting in greater initial healthcare costs, as well as outcomes with residual effects which reduce quality of life and continue to increase costs of health care over time. Second, that healthcare is a basic human right.

There was limited discussion regarding just the right wording and the resolution was amended by the delegates taking out the terms “equitable” related to access, and “essential” before healthcare services, which was the original language. The delegation did not want action to be delayed while the definitions of those two terms were debated! A second amendment introduced removing the words “documented and undocumented” in favor of the word “all”. This amendment was defeated leaving the language as presented above. The vote on the final resolution language was approximately 4 to 1 in favor.


Photo courtesy of the American Nurses Association, photograph by Day Walters Photography
Abstract
The purpose of this study was to examine the characteristics of nurses enrolled in the Indiana State Nurses Assistance Program (ISNAP) and to identify the top five drugs of choice. The sample consisted of 552 subjects who are currently in or have completed the ISNAP program. Known practice areas (n = 336) with the highest numbers of nurses in ISNAP were geriatrics (n = 142, 42.3%), medical-surgical (n = 71, 21.1%), emergency (n = 50, 14.9%), home care (n = 37, 11%), and critical care (n = 36, 11%). An investigation into these risk areas showed that opiates and alcohol were the most frequently abused drugs in each of these practice areas. Across all practice areas the nurses were predominantly female, had a mean age of 40 years old, did not divert drugs, worked full-time in a hospital as Registered Nurses (RNs), and worked on inpatient units. Although there was a need for further monitoring in a system where nurses are practicing more autonomously and caring for vulnerable patients. Findings also indicate more education related to addictions and treatment is needed at the individual and institutional level.

Identifying High And Low Risk Practice Areas And Drugs Of Choice Of Chemically Dependent Nurses
Jessica Furstenberg, Kawa Cheong, Ashley Brill, Angela M. McNelis, PhD, RN, Sara Horton-Deutsch, PhD, RN, and Pamela O’Haver Day, CNS, RN
Indiana University Purdue University Indianapolis IU School of Nursing
2010
Abstract
The American Nurses Association estimates that approximately 6-8% of nurses suffer from a chemical dependency to the degree that skill judgment is impaired (Trinkoff, Zhou, Storr, & Soeken, 2000). In order to counsel nurses at risk for substance use, abuse, or relapse, we need to identify high and low risk practice areas and drugs of choice. We know on the national level that nurses who practice in oncology, psychiatry, geriatrics, and emergency medicine are at high risk for chemical dependency (Trinkoff & Storr, 1998); however, no study to date has looked at these specific relationships for the state of Indiana. The purpose of this study was to determine if state trends were similar to national trends. Findings will be used to develop educational materials for career counseling. Working in collaboration with the Indiana State Board of Nursing (ISBN), the research team analyzed an existing data set of the Indiana State Nurses Assistance Program (ISNAP). There are approximately 110, 000 nurses in the state of Indiana and fewer than 1% are enrolled in the ISNAP program. The dataset contained de-identified information related to demographic characteristics, practice characteristics, substance(s), treatment, and outcomes. The dataset included 1,343 nurses consisting of 526 active participants and 658 past participants. The majority of the sample was female (88.2%) and classified as a registered nurse (69.4%). This was consistent with findings of the Bureau of Labor Statistics, which reported the number of registered male nurses was 5.6% at the end of 2005 and 8.3% at the end of 2008 for the state of Indiana. Primary drugs of choice were opiates followed by alcohol.
In the United States routine childhood vaccination for the prevention of vaccine-preventable disease (VPD) has been a major triumph of twentieth century public health efforts. Childhood vaccination rates across the United States are at all time highs. Gregory Poland M.D. (2007) compared the morbidty data from the pre-vaccine era in the early 1900s to the 1980s when many of the childhood vaccines were available. He noted a 99.43% reduction in morbidity in the following diseases: Diphtheria, Measles, Mumps, Pertussis, Polio (wild), Rubella, Congenital rubella syndrome, tetanus and Invasive HIB disease.

Unfortunately that has not been the case with adult immunization. Adult immunization efforts have been underfunded and overlooked throughout all levels of the public and private health sectors. Dr. Poland reports that the morbidity and mortality related to vaccine preventable diseases in adulthood is evidence of the scope of the problem. Each year between 50,000 and 70,000 adults and about 300 children die from vaccine preventable disease or their complications. That is approximately a 200 fold increase in the number of adult deaths compared to childhood deaths.

**Burden of illness due to VPD in the United States**

Finger and Francis (1998) examined the economic burden and mortality for influenza and pneumonia. It is estimated that in epidemic years, influenza kills between 20,000 and 40,000 people and causes 200,000 hospitalizations at a cost of $750 million to $1 billion. Pneumococcal disease accounts for 40,000 deaths each year, with morbidity estimated at 500,000 cases of pneumonia, 50,000 cases of sepsis and 3,000 cases of meningitis.

The third VPD with a heavy disease burden is Hepatitis B (HBV), due to the high morbidity and mortality associated with end-stage liver disease, cirrhosis and hepatocellular carcinoma, HCC. According to Lavanchy (2004) there are 1.25 million chronic HBV carriers in the United States. Approximately 15-40 % will develop liver failure, cirrhosis or HCC. One study conducted in South Korea estimates the economic burden, with the annual societal cost coming in at $959.7 million; 13.2 % for prevention (vaccine), 20.9 % for indirect costs (lost productivity) and $632.3 million to direct hospitalization costs. Clark (2008) examined the economic burden of individuals co-infected with HBV and HIV. In the most recent published comparison of the cost to treat chronic viral infections.

HIV accounts for higher medical expenses $4.5 billion vs. $51.4 million for HBV, annually. However those numbers do not take into account the high cost of HBV complications. HHV infection is the 10th leading cause of death worldwide and HCC is now the 5th most frequent cancer worldwide killing 300,000 to 500,000 people each year.

Although we have ample evidence that proves the efficacy of adult immunization in the prevention of VPDs, we also have ample evidence that we are missing the mark. The toll that is extracted in mortality, morbidity, lowered quality of life, lost productivity and medical complications is too high. As health care providers we must first educate our colleagues, other medical professionals and policy makers as well as our patients to make sure adults as well as children receive recommended adult immunizations.

Many adults, including some health care providers, underestimate the importance of adult immunization. Questions about vaccination return to diet questions as costs are discussed and routine in the practice of pediatrics but that has not been the case with clinicians treating adolescents and adults. While this is discouraging, we have an ample selection of resources to educate us. The Centers for Disease Control and Prevention (CDC) is the lead agency in the United States. Information for health care providers and consumers is readily available at www.cdc.gov/vaccines. All educational materials on the CDC website are available for downloading and distribution. It is an authoritative resource for the health care community as well as the public.

**The Advisory Committee on Immunization Practices (ACIP)**

The CDC along with the Department of Health and Human Services (HHS) oversees the Advisory Committee on Immunization Practices (ACIP) The ACIP is the federal agency that makes vaccine recommendations. The 15 member committee adolescents 11-12. Tdap should not be used for pregnant women but should be given during the immediate post partum period. Tdap is approved for adolescent and adults under age 65.

**Efficacy of Td and Tdap vaccines.** Td-When used properly the vaccine is nearly 100% effective in preventing tetanus and at least 85% effective in preventing diphtheria. Tdap-Pertussis has become more prevalent in the United States for the last 20 years, particularly among adolescents and adults. Childhood vaccination against Pertussis provides only 5 to 10 years of immunity, and antibiotics do little to affect the symptoms of Pertussis once coughing begins. According to Gregory Poland, M.D., studies show that Pertussis efficacy overall in adults is 92 %.

**Contraindications.** Persons that experience encephalopathy within 7 days after administration of
of a previous dose of diphtheria and tetanus toxoids and whole-cell pertussis vaccine (DTP), DtaP or Tdap not attributable to another cause should not receive future doses of a vaccine that contains pertussis.

Individuals with progressive neurological disorder should not receive DtaP until the neurologic status is clarified and stabilized.

HUMAN PAPILLOMAVIRUS (HPV)

In 2006 the first HPV vaccine was licensed by the FDA to protect against four of the most common strains of HPV. HPV vaccine is recommended for all females aged 11 through 26 years. Three doses should be administered. Administer the second dose 2 months after the first dose. The third dose should be given 6 months (at least 24 weeks) after the first dose. Females with a history of genital warts, abnormal Pap tests or positive HPV DNA test should still be given the vaccine. Ideally HPV should be administered before potential exposure through sexual activity; however females who are sexually active should still receive the vaccine consistent with age based recommendations.

Efficacy of HPV vaccine. According to information released by the CDC, Gardasil® protects against infection from 4 HPV types, including 2 types (HPV 16 and 18) that cause about 70% of cervical cancers. In clinical trials among women who had not yet been infected with a specific vaccine HPV type, the efficacy of the vaccine was close to 100% for prevention of pre-cancerous lesions of the cervix due to that type. For example, a woman who participated in the study and who did not have HPV type 16 before vaccination was afforded almost 100% protection against cervical pre-cancerous lesions caused by HPV type 16. Therefore, if girls/women are vaccinated before their first sexual experience, Gardasil® should remain effective in preventing about 70% of cervical cancers.

Precaution. HPV vaccine should not be administered during pregnancy. The vaccine has not been associated with adverse outcomes of pregnancy or with adverse effects on the developing fetus. However, data on vaccination during pregnancy are limited.

VARICELLA, CHICKENPOX

Varicella vaccine, introduced in the United States in 1995, is recommended for all adults without evidence of immunity to Varicella. Adults should receive 2 doses of single-antigen Varicella vaccine if not previously vaccinated unless there is a medical contraindication. The doses should be separated by a 4 week interval. Evidence of immunity may include documentation of 2 doses of Varicella vaccine. U.S. born before 1980, history of chickenpox, and laboratory evidence of immunity or laboratory confirmation of disease.

Efficacy of Varicella vaccine. Vaccine efficacy is estimated to be most commonly 80% to 85% (range 44% to 100%) against disease of any severity and 95% against severe disease.

CONTRAINDICATIONS. Women known to be pregnant or attempting pregnancy should not receive a varicella containing vaccine. Varicella vaccine is contraindicated for persons with immunocompromised conditions.

HERPES ZOSTER (SHINGLES) VACCINE

Zoster vaccine is recommended for adults aged 60 years and older regardless of whether they report a prior episode of herpes zoster. Although the data suggests that 5% of immunocompetent persons had a recurrence of shingles the recommendations support vaccination with zoster vaccine. Persons with chronic medical conditions may be vaccinated unless there is a medical contraindication.

Efficacy of Herpes Zoster (shingles) vaccine. Studies show a 51% reduction in herpes zoster across the population that receives shingles vaccine-adults aged 60 and over.

Contraindications. Shingles vaccine is not recommended for immunocompromised persons.

MEASLES, MUMPS, RUBELLA (MMR)

Measles vaccine became available in 1963. MMR first became available in 1971. The vaccines Measles, Mumps, Rubella and Varicella became available in 2005. See the schedule for specific recommendations on the age based recommendations for persons born before 1957 are considered immune to measles. Adults born during or after 1957 should receive one dose. Adults who did not receive a medical contraindication, documentation of 1 or more doses, or history of measles based on health care provider diagnosis or laboratory evidence of immunity. A second dose of MMR may be recommended for specific circumstances outlined in the adult immunization schedule. The same recommendations apply for the mumps component; persons born before 1957 generally are considered immune to mumps. Adults born during or after 1957 should receive 1 dose or more doses of mumps based on health care provider diagnosis or laboratory evidence of immunity. A second dose of MMR may be recommended for specific circumstances outlined in the adult immunization schedule. For the rubella component: 1 dose of Rubex® or other recommended is given to women whose rubella vaccination history is unreliable or who lack laboratory evidence of immunity. For women of childbearing age, rubella immunity is determined by laboratory serology. Rubella immunity should be determined and women should be counseled regarding congenital rubella syndrome.

Efficacy of Measles, Mumps, Rubella (MMR) vaccine. According to the CDC, MMR is effective in preventing illness in 95% of recipients of one dose.

Contraindications. Pregnancy is a contraindication to receiving MMR vaccine of healthy persons. Persons with immunocompromised conditions should not receive MMR vaccine.

INFLUENZA

Annual immunization is recommended for all adults age 50 and over as well as all children age 6 months to 18 years.

All individuals with the following medical conditions could get this vaccine: cardiovascular or pulmonary disease including asthma, chronic metabolic diseases, including diabetes mellitus, renal or hepatic dysfunction, hemoglobinopathies, or any immunocompromising conditions, and any condition that compromises respiratory function or the handling of respiratory secretions or that can increase the risk of aspiration (e.g., cognitive dysfunction, spinal cord injury, or seizure disorder or other neuromuscular disorder); and pregnancy during the influenza season.

Occupational indications. All health care personnel, including those employed by long term care and assisted living facilities, and caregivers of children less than 5 years old.

Other indications. Residents of nursing homes and other long term care and assisted living facilities, persons likely to transmit influenza to persons at high risk (e.g., in-home household contacts and caregivers of children aged less than 5 years old and anyone who would like to decrease their risk of getting influenza). Healthy, non-pregnant adults aged less than 50 years without high risk medical conditions who are not contacts of severely immunocompromised persons in special care units can receive either intramuscularly administered, live attenuated (FlmMist®) or parenterally administered inactivated vaccine.

Efficacy of influenza vaccine. Efficacy is designed to prevent morbidity and mortality. The success of influenza vaccine is proven by a 50%-70% reduction in hospitalization and reduction in deaths and 30%-70% reduction in illness.

Contraindications. Influenza vaccine should not be administered to persons with an allergy to egg proteins.

PNEUMOCOCCAL POLYSACCHARIDE (PPSV)

The pneumococcal conjugate vaccine (PCV) for persons aged 65 and over, was recommended in 2005. See the schedule for specific recommendations on the age based recommendations for persons aged 65 and over. Pneumococcal polysaccharide vaccine (PPSV) is recommended for persons aged 65 and over.

The vaccine is also recommended for persons age 64 and under with chronic cardiovascular or pulmonary disease, diabetes mellitus, alcoholism, chronic liver or renal disease, SFLE, SFLE, cocooners, or functional or actual asplenia, and immunocompromising conditions as well as those who live in facilities. This year the recommendations were expanded to include asthma and cigarette smoking as indications for the vaccine.

Revaccination: One-time revaccination after 5 years is recommended for persons with specific chronic medical conditions and persons who are not recommended to be vaccinated. For persons age 65 and over and one-time revaccination if they were vaccinated 5 or more years previously and were aged less than 65 years.

Efficacy of pneumococcal vaccine. According to the CDC, more than 80% of healthy adults who receive PCV23 develop antibodies against 14 pneumococcal contained in the vaccine, usually within 2 to 3 weeks after vaccination. Older adults and persons with some chronic illnesses or immunodeficiency may not respond as well, if at all.

Contraindications. Persons who had a serious reaction to a previous dose should not receive another dose (such reactions are rare).

HEPATITIS A

This vaccine licensed in 1995 is medically immunocompromised persons. Hepatitis A vaccine is approved by the FDA for persons receiving clotting factor concentrates. It is also recommended for men who have sex with men and persons who use illegal drugs. Other groups include persons working with the hepatitis A (HAV) virus in infected primates or with HAV in the laboratory setting, persons traveling to or working in countries with high levels of HAV and any person seeking protection from HAV infection.

Vaccine dose antigen Havrix® or Vaqta® is given in a two dose schedule at 0 and 6-12 months. There is no alternate or accelerated schedule for single antigen Hepatitis A vaccine.

Efficacy of Hepatitis A vaccine. The CDC reports that 95% of adults will develop protective antibody within 4 weeks of a single dose of Hepatitis A vaccine and nearly 100% will seroconvert after two doses.

Contraindications. Persons who had a serious reaction to a prior dose should not receive the second dose of this vaccine.

Precaution. Women who are pregnant should not receive Hepatitis A vaccine. The safety of this vaccine for pregnancy has not been determined; but there is no evidence that it is harmful to either the pregnant woman or fetus.

HEPATITIS B

Hepatitis B vaccine approved by the FDA since 1981 is recommended for persons with end stage renal disease, persons receiving hemodialysis; persons with HIV infection and persons with chronic liver disease. It is also recommended for health care workers a indicated safety workers who are exposed to blood or other potentially infectious body fluids. Sexually active persons who are not in a long term, mutually monogamous relationship (more than one sex partner during the previous 6 months); persons seeking evaluation or treatment for a sexual behavior that places them at risk to recent drug users and men who have sex with men.

Household contacts and sex partners of persons with chronic HBV infection; clients and staff members of institutions for persons with
is a person whose compliance with medical follow- up is not likely.

Persons with moderate or severe acute illness should be vaccinated when the condition improves, after screening for contraindications.

ADVERSE REACTIONS

An adverse reaction is defined as an untoward effect that occurs after vaccination. They are generally broken down into three categories: local, systemic and allergic. Local reactions are the most common and usually result from the vaccine and swelling at the injection site that is self-limited and mild.

Systemic reactions are more generalized and include fever, malaise, myalgia, headache and loss of appetite. These symptoms are nonspecific and may be caused by the vaccine or something unrelated to the vaccine. They may be caused by viral infection, stress or excessive alcohol consumption.

Allergic reactions are the third type of reaction. They can be caused by the vaccine itself or a component of the vaccine. Severe allergic reactions can be life-threatening. They are rare and occur in less than one in every half million doses. The risk of an allergic reaction can be minimized by good screening prior to vaccination. All providers who administer vaccines must have an emergency protocol and supplies to treat anaphylaxis.

BARRIERS TO ADULT IMMUNIZATION

Barriers to adult immunization occur at all levels. There are many barriers, and enough blame to go around, as many as the vaccination rate among adults continues to lag far behind vaccination rates for children. In the provider community, lack of time, too many patients to immunize and lack of knowledge are the primary contraindications to vaccination.

Contraindication that is applicable to all vaccines is a history of a severe allergic reaction after a previous dose of vaccine or to a vaccine component. An example would be an individual with a serious allergy to egg protein, that person should not receive influenza vaccine. Persons with severe immunocompromised conditions should not receive live, attenuated vaccines. In addition, pregnancy is a contraindication for all vaccines after the first trimester.

Precautions, on the other hand, generally indicate a temporary delay in the delivery of a vaccine, not an absolute contraindication. When a contraindication is present, vaccination should not take place. The contraindication that is applicable to all vaccines is a history of a severe allergic reaction after a previous dose of vaccine or to a vaccine component. An example would be an individual with a serious allergy to egg protein, that person should not receive influenza vaccine. Persons with severe immunocompromised conditions should not receive live, attenuated vaccines. In addition, pregnancy is a contraindication for all vaccines after the first trimester.

At the national level, the national immunization program spends less than 3% of its budget on adult immunization. Although the need for public health and severe acute illness with or without the presence of fever.

In many instances, clinicians fail to vaccinate patients due to inadequate knowledge of true contraindications or precautions to vaccination. More often than not this leads to missed opportunities to vaccinate instances where it is generally appropriate to vaccinate include cases of diarrhea, minor upper respiratory tract infections (including otitis media) with or without fever, minor skin reactions (not presumed to be due to vaccine), current antimicrobial therapy and the convalescent phase of an acute illness. Failure to vaccinate persons with minor acute illnesses may seriously impede vaccination efforts particularly if it
Partner with the community
Patient oriented and community based approaches are used to reach target populations.

The revised standards provide a concise, convenient summary of best practices. They have been widely endorsed by major professional organizations including the American Nurses Association.

As the ACIP notes in the General Recommendations on Immunization, there are benefits and risks associated with using all vaccines. The benefits to the individual and to society as a whole include partial or complete protection against vaccine preventable disease for the vaccinated person and the creation and maintenance of herd immunity, prevention of disease outbreaks and reduction in health care related costs.

Reference
Centers for Disease Control and Prevention: http://www.cdc.gov/vaccines/recs/acip/default.htm
Centers for Disease Control and Prevention: General Recommendations on Immunization; MMWR Recommendations and Reports December 1, 2006/55 (RR15): 1-48
Centers for Disease Control and Prevention: Recommended Adult Immunization Schedule-United States, 2009 MMWR Weekly quick guide January 9, 2009/Vol 58/No. 03

INDEPENDENT STUDY
This independent study has been developed for nurses to increase understanding about adult immunizations. 1.0 contact hour will be awarded for successful completion of this independent study.
The Ohio Nurses Foundation (OBN-001-91) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.
Expires 8/2011. Copyright © 2009, Ohio Nurses Foundation

DIRECTIONS
1. Please read carefully the enclosed article “The Importance of Adult Immunization.”
2. Complete the post-test, evaluation form and the registration form.
3. When you have completed all of the information, return the following to the Indiana State Nurses Association, 2915 North High School Rd, Indianapolis, IN 46224:
   A. The post-test;
   B. The completed registration form;
   C. The evaluation form; and
   D. The fee: ISNA Member ($15) – NON ISNA Member ($20)

The post-test will be reviewed. If a score of 70 percent or better is achieved, a certificate will be sent to you. If a score of 70 percent is not achieved, a letter of notification of the final score and a second post-test will be sent to you. We recommend that this independent study be reviewed prior to taking the second post-test. If a score of 70 percent is achieved on the second post-test, a certificate will be issued.

If you have any questions, please feel free to call Zandra Ohri, MA, MS, RN, Director, Nursing Education, zohri@ohnurses.org, 614-448-1027; or Sandy Swearingen, sweeringen@ohnurses.org, 614-448-1030, Ohio Nurses Foundation at (614) 237-5414.

OBJECTIVES
Upon completion of this independent study, the learner will be able to:
1. Describe the immunizations that adults should receive.

This independent study was developed by: Kathy Papp, RN, MSN, The author and planning committee members have declared no conflict of interest.

There is no commercial support for this independent study.
DIRECTIONS: Please complete the post-test and evaluation form. There is only one answer per question. The evaluation questions must be completed and returned with the post-test to receive a certificate.

Name: ________________________________
Final Score: __________________________

Please circle one answer.

1. Childhood and adult immunization efforts have been a major accomplishment in the last 100 years.
   A. True  B. False

2. Adolescents and adults have adequate protection against most vaccine preventable diseases.
   A. True  B. False

3. The Advisory Committee on Immunization Practices, the ACIP, is the federal agency that publishes vaccine recommendations each year.
   A. True  B. False

4. Vaccine Preventable Diseases (VPDs) are responsible for greater than 50,000 adult deaths each year.
   A. True  B. False

5. Which three VPDs currently cause the greatest economic burden to society in the United States?
   A. Polio, Measles, Herpes Zoster
   B. Influenza, Pneumonia, Hepatitis B
   C. Diphtheria, Tetanus, Pertussis

6. Information on the CDC website is copyright protected and not available for general distribution.
   A. True  B. False

7. Tdap, the tetanus, diphtheria, pertussis vaccine, recommended for adolescents and adults should be given to women in the immediate post partum period.
   A. True  B. False

8. The ACIP no longer recommends Td, tetanus diphtheria vaccine, as prophylaxis in wound management.
   A. True  B. False

9. HPV, the Human Papillomavirus vaccine is recommended for all females aged 11 through 26 years.
   A. True  B. False

10. Adults without evidence of immunity to Varicella vaccine should receive two doses of single antigen Varicella vaccine.
    A. True  B. False

11. Herpes Zoster vaccine is recommended for adults aged 40 years and older.
    A. True  B. False

12. Measles, Mumps and Rubella (MMR) is generally not recommended for adults born before 1957.
    A. True  B. False

13. Annual influenza vaccination is only recommended for adults aged 50 and over.
    A. True  B. False

14. Older adults and adults with immunodeficiency may not respond well to pneumococcal vaccine.
    A. True  B. False

15. Twinrix, the combined Hepatitis A/B vaccine can be administered on an accelerated 4 dose schedule instead of the recommended 3 dose schedule.
    A. True  B. False

16. Hepatitis A vaccine has nearly 100% seroconversion after two doses.
    A. True  B. False

17. The national immunization program spends more than 10% of its budget on adult immunization.
    A. True  B. False

18. Barriers to adult immunization at the patient level include limited financial resources, fragmented care, lack of knowledge and fear.
    A. True  B. False

19. The Institute of Medicine (IOM) developed a conceptual framework which identified 3 fundamental roles of the national immunization system.
    A. True  B. False

20. The Standards for Adult Immunization Practices first published in 1990 have been endorsed by the American Nurses Association.
    A. True  B. False

Evaluation:

1. Were the following objectives met?
   a. Describe the immunization that adults should receive.  Yes  No

2. Was this independent study an effective method of learning?  Yes  No
   If no, please comment:

3. How long did it take you to complete the study, the post-test, and the evaluation form?  __________

4. What other topics would you like to see addressed in an independent study?

The Importance of Adult Immunization
ONF-09-20-I
Registration Form

Name: _____________________________________________
(Please print clearly)
Address: __________________________________________
___________________________________________________
City/State/Zip
Daytime phone number: ____________________________
_______ RN  ________  LPN
Fee:  ________  ISNA Member ($15)
 ________  Non-ISNA Member ($20)
Please email my certificate to: __________________________
Email Address (please print clearly)

MAKE CHECK PAYABLE TO THE INDIANA STATE NURSES ASSOCIATION.

Enclose this form with the post-test, your check, and the evaluation and send to:
ISNA, 2915 North High School Road, Indianapolis, IN 46224.

ISNA OFFICE USE ONLY
Date Received: ____________ Amount: ______________
Check No ________________
Paula Davies Scimeca, MS, RN, author of “Unbecoming A Nurse: Bypassing the Hidden Chemical Dependency Trap” will present the keynote address at the annual ISNA’s Indiana State Nurses Assistance Program (ISNAP) conference. Registration is now available online at www.IndianaNurses.org.

ALL TIMES EDT
8:30 Registration
8:55 Welcome—Barbara Kelly, ISNA President
9:00 Addiction—A New Paradigm—
   Richard Hinchman, MD—Addictionist
   Dr. Hinchman will be talking about how drug addiction is a brain disease. Recent studies have increased our knowledge of how drugs affect brain circuitry and how these factors affect human behavior.
10:00 Break
10:15 Unbecoming A Nurse”—
   Paula Davies Scimeca, RN, MS
   Ms. Scimeca will be highlighting the innate and professional risk factors, as well as the measures which may prevent the development of an addiction in the first place. She will challenge us to look at our attitudes about nurses caught in the cross hairs of chemical dependency.
11:45 Lunch
12:45 Unbecoming A Nurse—cont.
2:45 Break
3:00 Uncovering the Secret
   Four nurses share their stories of addition & recovery.
4:00 Questions/Evaluation/Contact Hours
4:15 Adjournment
   An application has been submitted to the Ohio Nurses Association (OBN-001-91), for approval of 5.75 contact hours. Ohio Nurses Association is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.